OLIVIE	RS FOR MEDICARE	M THE AND HUMAN SERVICES & MEDICAID SERVICES	46	# 5123115	7 _{PRIT} P. 5 FORM	APPRO
WIEWEN.	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO (X3) DAT CON	E SURVEY MPLETED
 -		445343	B. WING			
IAME OF I	PROVIDER OR SUPPLIER	-	' 	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	08/201
RIDGE	AT SOUTH PITTSBUI	RG, THE		201 EAST 10TH STREET		
(X4) ID	SUMMARYSTA	TEMENT OF DEFICIENCIES	, _	SOUTH PITTSBURG, TN 37380		
PRÉFIX _JAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	COMPLE DATE
F 000	INITIAL COMMENT	s	F 000			
F 167 SS=D	and #35864 conductions #3544 and #35864 conductions at South Pitts cited in relation to the PART 483, Required Facilities. 483.10(b)(11) NOTH (INJURY/DECLINE/A facility must immed consult with the residence or an interested famous accident involving the injury and has the position of the properties	ROOM, ETC) diately inform the resident; dent's physician; and if sident's legal representative ily member when there is an e resident which results in patential for requiring physician cant change in the resident's esychosocial status (i.e., a h, mental, or psychosocial reatening conditions or si); a need to alter treatment		The Bridge at South Pittsburg of believe and does not admit to deficiencies existed either before, do after the survey. The Facility reserves the survey findings informal dispute resolution, format proceedings or any administrative proceedings. This plan of correction meant to establish any standard contract obligation or position as facility reserves all rights to raise all contentions and defenses in any type or criminal claim, action or proceedings contained in this plan of conshould be considered as a waiver potentially applicable Peer Review, Assurance or self-critical examprivilege which the facility does not and reserves the right to assert administrative, civil or criminal claim or proceeding. The Facility offer response, credible allegations of comand plan of correction as part of its offerts to provide quality of care residents.	hat any uring, or erves all through appeal or legal or le	
S	or interested family method in the restance of the standard in section of restance in \$483,150	promptly notify the resident ident's legal representative tember when there is a promate assignment as (e)(2); or a change in	F 157	F157 Notify of Changes (Injury / De Room, etc)		5/22/15
ti	egulations as specifi his section.	rederal or State law or ed in paragraph (b)(1) of		The facility will immediately infor resident; consult with the resident; and if known, notify the resident representative or an interested member when there is an accident in	ident's ident's family	
	WELLOWS ON PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		DATE
	7000	<i>AD</i> ∼		ADMINISTRATOR	(/4	

An oth foll day documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-98) Previous Versions Obsolete

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Event ID: 2MJE11

Facility ID: TN5801

DEApr. 30. 2015 7:59PM THE DUMAN SERVICES No. 5717 PRI.P. 6: 04/14/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ 445343 B. WING NAME OF PROVIDER OR SUPPLIER 04/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG. REGULATORY OR LSC IDENTIFYING INFORMATION COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY the resident which results in injury and has F 157 Continued From page 1 F 157 The facility must record and periodically update potential for requiring physician intervention; a significant change in the the address and phone number of the resident's legal representative or interested family member. resident's physical, mental, or psychosocial status (i.e. physical, mental, or psychosocial status in either life threatening conditions or This REQUIREMENT is not met as evidenced clinical complications); a need to alter by: treatment significantly (i.e., a need to Based on review of facility policy, medical record discontinue an existing form of treatment review, review of facility investigations, and due to adverse consequences, or to interview, the facility falled to notify a family member after a fall for one resident (#56) of four commence a new form of treatment); or to residents reviewed of thirty-nine sampled commence a new form of treatment); or a residents. decision to transfer or discharge the resident from the facility as specified in 473.12(a). The findings included: The facility will also promptly notify the Review of the facility policy titled Fall Policy dated resident and, if known, the resident's legal April 2012, revealed "...if fall occurs the following representative or interested family member actions will be taken ... e. Notify physician and when there is a change in room or roommate family..." assignment as specified in 483.15(e)(2); or a change in resident rights under Federal or Medical record review revealed Resident #56 was admitted to the facility on 10/8/12 with diagnoses State law or regulations as specified in including Alzheimer's Disease, Hypertension, paragraph (b)(1) of this section. Chronic Kidney Disease Stage 2, Generalized Anxiety, Mood Disorder, Depressive Disorder, The Facility will record and periodically Psychosis, Difficulty Walking and Personal update the address and phone number of History of Falls. the resident's legal representative or Interested family member. Medical record review of the quarterly Minimum Data Set (MDS) dated 3/30/15 revealed the

dated 3/24/15 revealed, "...On patients return to FORM CMS-2567(02-99) Previous Versions Obsolete

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resident scored a 9 on the Brief Interview for Mental Status (BIMS), Indicating the resident was

with one person physical assist.

moderately cognitively impaired, was only able to

stabilize with staff assistance, and walked in room

Review of a facility investigation for Resident #56

Facility ID: TN\$801

Residents Affected:

04/28/15.

#56's fall that occurred 3/24/15.

DOM

representative (conservator) of Resident

notified

If continuation sheet Page 2 of 7

legal

DEADY, 30. 2015. 7:59PM THE CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 5717 PRIP. 7); 04/14/2015 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	PROVIDER OR SUPPLIER	445343 RG, THE	B. WING	S	STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST 10TH STREET	04	/08/2015	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF CORRECTY)	BE	(X5) COMPLETION DATE	
F 157	bed, she fell in the fresident in floor on a arm. Range of motic completed and with stable. When asked replied, 'I just fell. Prassisted patient to scontinued transfer finotedNotifications Practitioner]-3/24/20 received: NP-3/24/20 Interview with Direct 4/8/15 at 9:46 AM, in confirmed there was Nursing Assessment Nursing Notes regar the fall, and the facilinotification of family. 483.13(c) DEVELOF ABUSE/NEGLECT, The facility must dev	loor. This nurse found abdomen resting on her left on and full body assessment in normal limits. Vital signs about occurrence resident eriod. Nurse x2 [two nurses] itting position and then rom floor to bedNo injuries and orders doctor: NP [Nurse x2 15 7:20 amOrders 2015 7:20 amOrders 2015 7:20 am" For of Nursing (DON) on the conference room, and documentation in the fight failed to follow policy for PIMPLMENT ETC POLICIES	F 157	157	Residents Potentially Affected: All residents who have experienced have the potential to be affected be cited practice. By 5/22/15, DON / UN conduct audit of medical record a event manager of residents who experienced falls within the last 90 pon/ UMs will notify responsible partindicated based on findings of audit 5/22/15. Systemic Measures: DON/SDC will educate nursing staff (I RN) on facility Fall Policy by 5/2 DON/SDC to provide competency te nursing staff on Fall Policy by 5/22/15. Monitoring Measures:	Residents Potentially Affected: All residents who have experienced a fall have the potential to be affected by this cited practice. By 5/22/15, DON / UMs will conduct audit of medical record and/or event manager of residents who have experienced falls within the last 90 days. DON/ UMs will notify responsible parties if indicated based on findings of audit by 5/22/15. Systemic Measures: DON/SDC will educate nursing staff (LPN / RN) on facility Fall Policy by 5/22/15. DON/SDC to provide competency test to nursing staff on Fall Policy by 5/22/15.		
	mistreatment, negled and misappropriation This REQUIREMENT by: Based on review of facility and misappropriation.	res that prohibit ct, and abuse of residents of resident property. I is not met as evidenced acillty policy, medical record lity investigations, and failed to implement the resident (#130) of five			Resident falls will be discussed in clinical meeting (Mon-Fri) documentation reviewed by the QA to Any Identified concerns related notification compliance will be corresimmediately and reported to Administrator and education will be guntil compliance achieved. Compliance is will be addressed in monthly QA x 3 motor recommendations and further follows indicated.	eand to to ected the given sues		

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Apr. 30. 2015 8:00PM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 5717_{PRII}P. 8: 04/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(YZ) MILITER E CONTRACTOR				MB NO. 0938-0391		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
-		445343	B. WING	;		04	/08/2015		
NAME OF	PROVIDER OR SUPPLIER		.,	r	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04	108/2015		
BRIDGE	AT SOUTH PITTSBU	DO THE	i		OI EAST 10TH STREET				
	A VOUNTINGE	KG, IHE	j	1	SOUTH PITTSBURG, TN 37380				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID						
PREFIX	I (EACH DEFICIENC)	ENCY MUST BE PRECEDED BY FIRE		ΣX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETION		
——;ТАG——	BEGULATORY OR USC IDENTIFYING INFORMATION)				CROSS-REFERENCED TO THE APPROPRIATE		DATE		
 ,	<u></u>				DEFICIENCY)		_		
F 226	0	_			F226 Develop / Implement Abuse / Neg		5/22/15		
F &20	Continued From page 3		F2	226	Etc Policies		مدرعم رد		
	D-12- 60 11-1						·		
r	review of facility po	plicy titled "Abuse, Neglect,			The facility will develop and implement		;]		
	March 2013 rover	on" most recently revised in			written policies and procedures that prol	athir I			
	are reported impor	led, "All allegations of abuse diately to the charge			mistreatment, neglect, and abuse of	11011			
	DUISE. The charge	nurse will immediately notify			residents and misappropriation.	ŀ]		
	the Administrator, f	DON [Director of Nursing]"		i	Tookeering and triiseppropriation:	i	. 1		
•	(with mod ditor) t	Sold forector or (driskid)"."			Residents Affected:	-	[]		
I	Medical record revi	ew revealed Resident #130			- Interest		[]		
	was admitted to the	facility on 2/21/15 with			Investigation began by Administrator on		1 !		
	alagnoses including	Dementia with Behavior			3/3/15 to ensure safety of Resident #130		1 1		
	Disturbance.	3			Alleged CNA was immediately suspended				
				ļ	ono 3/3/15 pending outcome of the	i			
	Medical record revi	ew of a Minimum Data Set			investigation, investigation concluded that				
i	dated 2/28/15 revealed the resident's Brief			ļ	allegation was unsubstantiated with no	rt :	} I		
	interview of Mental	Status score was five,		i	Salvarra officer to continue to the Mith No	.	l '		
	indicating impaired	cognitive ability.			adverse effects to resident. LPN#1 provid	ed	j		
	Review of a facility	Investigation dated 3/2/15,			one-on-one in-service by DON on 3/3/15	on			
- 1	and signed by Certi	fied Nursing Assistant (CNA)			facility Abuse Policy, including reporting requirements.	ì			
Ĩ	#1, revealed. "inv	estigation Regarding:		-	reducentents.		i l		
i	[Kesident #130]D:	ate Incident Occurred		- 1	Residents Potentially Affected:	[
	3-2-2015i was in t	he room with ICNA #21 at		- 1		i	1		
	7.30 PMI Went into	0 the moon at 9:28 and down			All residents who have alleged abuse have	<u>.</u>	ĺ		
	fresidenti a clean co	Omforter and fresidenti		1	the potential to be affected by this cited	'			
- 1	statedarm was hu	rting b/c (because) I boot			practice. Administrator reviewed all	- {	i !		
- 1	tregidenti, immediat	ElV 02Ve fresidenti the blanket		- [investigations / State Reportables for last	60			
1	and told the nurse w	/hat was stated"			days on 4/29/15 with no compliance issue		'		
	Review of a feetile -1			-	noted.	*	l f		
1	and signed by Lices	nvestigation dated 3/2/15,		1		, ,			
ļ	#1. revealed "CNA	sed Practical Nurse (LPN) [#2] approached me and told			Systemic Measures:				
	me that [residenfl w	as hurting & [and] that				11			
	[resident] told CNA	not to hit fresidently again.			Administrator / SDC to conduct in-service				
!	[resident] told CNA not to hit [resident] again"			1	with staff on facility Abuse Policy by 5/22				
	Review of facility inv	restigation dated 3/3/15, and			Administrator or SDC will complete abuse				
	signed by the DOM.	revealed. * This morning I			training with all new employees upon hire	, !	1		
	received notice that	[resident] stated a one had			during orientation prior to assuming posit	ion			
	beaten fresidenti un	I reported this			an the fla-		l.		

DEIAPT. 30. 2015 8:01PM THE CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 5717 PRIIP. 9: 04/14/2015 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
		SELLIFICATION NOWBEK	A BUILI	A BUILDING		COMPLETED		
NAME OF PROVIDER OR SUPPLIER		445343	B. WING	B. WING		04/08/2015		
BRIDGE AT SOUTH PITTSBURG, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380			0072010	-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL BEGULATORY OR LSC IDENTIFYING INFORMATION)					BE	(X5) COMPLETION DATE	
				_	DEFICIENCY)***			-
F 226	Continued From partoadmininstrator	ge 4 ."	F 2	226	Monitoring Measures:			7
-	Interview with the D the therapy room, reimmediately notified and confirmed the fabuse policy for Res 483.20(k)(3)(i) SER PROFESSIONALS: The services provide must meet professionals are professionals. This REQUIREMENT by: Based on medical refine facility falled to find one resident (#43) or residents. The findings included Medical record review.	ON on 4/7/15 at 4:28 PM, in evealed the DON was not of the resident's allegations acility failed to implement the sident #130. VICES PROVIDED MEET TANDARDS ed or arranged by the facility onal standards of quality. T is not met as evidenced ecord review and interview, ollow a physician's order for f thirty-nine sampled	F 28	1	Abuse investigations will be discussed of (Mon-Fri) in morning Clinical Meeting ar reviewed by QA team to ensure compliance with Abuse Policy. Any noted compliance issues will be addressed accordingly at time and forwarded to the QA committed Any identified concerns related to compliance with facility Abuse Policy will addressed immediately and reported to Administrator. Concerns will be address monthly QA meeting x 3 months for recommendations and further follow-up indicated. FZ81 — Services Provided Meet Professional Standards The services provided or arranged by the facility will meet professional standards of quality.	nce e hat ee. l be the ed in eas enal eas eas	5/22/15	
	Medical record review revealed Resident #43 was admitted to the facility on 1/1/15 with diagnoses ancluding Alzheimer's Disease and Lower Extremity Edema. Medical record review of a physician's order lated 1/1/15 revealed, "PT/OT/ST to eval and to the interest of the physician in the physician				Residents Affected: No changes can be made to Resident #43 due to discharging home on 3/9/15. Residents Potentially Affected:			
	Therapy to evaluate a Medical record review Teated by PT and OT 3/9/15. Continued rev	ccupational Therapy/Speech and treat]." v revealed the resident was			All residents with order for Speech Theral have the potential to be affected by this cited practice related to professional standards. DON / UMs / RSM to audit spetherapy orders for residents admitted in a past 90 days by 5/22/15. DON / UMs / RS to address issues found during audit as	ech he		
DL / C2 / C					indicated.	- i I	ŀ	

Apr. 30. 2015 8:01PM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 5717;RINP. 10:34/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED	<u> </u>
		445343	B. WING	<u> </u>	04/08/2015		
NAME OF PROVIDER OR SUPPLIER BRIDGE AT SOUTH PITTSBURG, THE				STREET ADDRESS, CITY, STATE, ZIP COD 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380	E E	100/20 <u>13</u>	
(X4) ID PREFIX TAĞ	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			O(5) COMPLETION DATE	1
F 281	81 Continued From page 5 Interview with a corporate nurse on 4/8/15, at		F2	281 Systemic Measures:			
F 514 \$5≐D	11:05 AM, in the confacility was unable to regarding a Speech confirmed the facility physician's order for 483.75(I)(1) RES RECORDS-COMPILE The facility must make resident in accordant standards and practically document systematically organization to identification to identificati	ofference room, revealed the provide documentation of provide documentation of the provide documentation and y failed to follow the resident #43. ETE/ACCURATE/ACCESSIB clintain clinical records on each nee with accepted professional lices that are complete; nited; readily accessible; and nized. must contain sufficient for the resident; a record of the		Regional Therapy Director to cond service with therapists by 5/22/15 following physician orders for evaluand treatment. Monitoring Measures: DON / UMs / RSM to conduct randomorbily x 3 months to monitor or with physician orders. Therapy or brought to daily Clinical Meeting and communicated to Rehab Marthey are written. Any identified or related to following of physician of be corrected immediately and repthe Administrator. Concerns will in the Administrator.	dom audit ompliance ders will be (Mon-Fri) nager as oncerns orders will		
2.0	services provided; the preadmission scree and progress notes. This REQUIREMENT by:	ants; the plan of care and the results of any ning conducted by the State; T is not met as evidenced	F 51	addressed in monthly QA x 3 mor recommendations and further fol indicated. 4 F514 – Res Records – Complete /A Accessible	llow-up as	5/20/1 5 Ox telephon	
	maintain a complete resident (#13) of thir	medical record for one fy-nine sampled residents.		The facility will maintain clinical receath resident in accordance with accordance with accordance with accordance complete; accurately documented;	ccepted s that are readily	Slaalis I'K	DA.
	Closed Records" dat "Assembling the m completed at the tim	icy titled "Chart Order - ted March 2013, revealed, edical record shall be		accessible; and systematically organized the clinical record will contain sufficient information to identify the resident of the resident's assessments; the pareadmission screening conducted. State; and progress notes.	cient ; a record plan of ults of any) · · · (

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Apr. 30. 2015 8:02PM THE No. 5717 PRIIP. 11 04/14/2015 PARTIMENT UF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: A. BUILDING COMPLETED 445343 B. WING 04/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET BRIDGE AT SOUTH PITTSBURG, THE SOUTH PITTSBURG, TN 37380 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST SE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG. DATE

(X5) PLETIÓN REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 514 Continued From page 6 F 514 Residents Affected: shall be responsible for ... arranging the medical record for final disposition...Health information No changes can be made to Resident #13's shall file a written report with the administrator of medical record due to resident expiring on any incomplete closed record...Medical records 2/24/15. shall be...completed within thirty (30) days of discharge..." Residents Potentially Affected: Medical record review revealed Resident #13 was All residents who have discharged from the admitted to the facility on 1/30/15 with diagnoses facility have the potential to be affected by including Alzhelmer's Dementia. this cited practice. DON/ UMs will audit all discharge summaries from the last 90 days Medical record review of a physician's order by 5/22/15 for completeness and accuracy. dated 2/23/15 revealed, *DNR [Do Not DON / UMs to address issues found during Resuscitate] Palliative Measures." audit as indicated. Medical record review of a nurse's note dated 2/24/15 at 4:10 PM, revealed, "no spontaneous Systemic Measures: VS [vital signs]...family request body be released..." DON or Administrator to in-service Interdisciplinary Team by 5/22/15 on facility Medical record review of a Discharge Summary Medical Record Policy for accuracy and dated 2/24/15 revealed the resident expired on completion of discharge summaries. 2/24/15. Continued review revealed the interdisciplinary summaries regarding the Monitoring Measures: resident's stay were blank. Discharge summaries will be brought to daily Interview with the Director of Medical Records on Clinical Meeting (Mon-Fri) for review and 4/8/15 at 1:42 PM, in the corridor outside the completion. Any identified concerns related conference room, confirmed the facility failed to to completeness of medical records will be maintain a complete medical record for Resident corrected immediately, reported to the #13. Administrator and education completed until compliance is achieved. Concerns will be addressed in monthly QA x 3 months for recommendations and further follow up was indicated.